

RYAN WHITE CARE ACT HEALTH INSURANCE CONTINUATION PREMIUM PAYMENT REFERRAL APPLICATION

1. NAME OF CLIENT—Last		First	Middle Initial	2. CLIENT'S SOCIAL SECURITY NUMBER	
3. CLIENT'S ADDRESS—Number/Street		4. CITY AND COUNTY		5. STATE	6. ZIP CODE
7. NAME OF POLICYHOLDER AND SOCIAL SECURITY NUMBER—If Different				8. CLIENT'S TELEPHONE NUMBER ()	
11. POLICY STATUS: Premium <input type="checkbox"/> IS <input type="checkbox"/> WAS Due On: _____ Grace Period Ends: _____			11.a. STATE USE ONLY		
12. PREMIUM AMOUNT \$ _____ (monthly)			12.a. STATE USE ONLY Amount to be Paid \$ _____ <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly		
13. PAYMENT INFORMATION					
MAKE PAYMENT TO			TELEPHONE NUMBER ()		CONTACT PERSON
ADDRESS—Number/Street		City	State	ZIP Code	PAYEE'S FEDERAL TAX ID NUMBER

IMPORTANT: Please note that in order to comply with the Federal Privacy Act (42 USC, Section 552a) your social security number and any information you provide may be used to contact insurance companies, employers, providers of health care services, and county agencies to determine the extent of available health insurance. Under Welfare and Institutions Code, Section 14100.2, any submitted information is considered confidential.

DECLARATION: In signing, I declare that I meet all eligibility requirements, and that I am not enrolled in the AIDS Drug Assistance Program to obtain outpatient prescription drugs that can be covered by private health insurance.

AUTHORIZATION TO OBTAIN INFORMATION: "I hereby authorize _____ and the California Department of Health Services to obtain, if needed, any information regarding my private health insurance coverage, including payments and/or benefits for medical care made on my behalf, which may be used to determine if the Department will pay health insurance premiums for continued coverage."

➤
Signature of Client _____ Date _____

➤
Signature of Policyholder (if different) _____ Date _____

AGENCY USE ONLY

1. ORGANIZATION NAME	2. BENEFITS COUNSELOR NAME	3. TELEPHONE NUMBER ()
4. ADDRESS—Number/Street	5. CITY AND ZIP CODE	6. FAX NUMBER

DECLARATION: All eligibility requirements have been met.

	Signature of Benefits Counselor/Case Manager	Date
Original	_____	_____
Re-cert 1	_____	_____
Re-cert 2	_____	_____
Re-cert 3	_____	_____

AUTHORIZATION TO PAY PREMIUM

WELFARE AND INSTITUTIONS CODE, SECTION 14124.91, ALLOWS THE DEPARTMENT OF HEALTH SERVICES TO PAY THE PREMIUM FOR THIRD-PARTY COVERAGE FOR ELIGIBLE APPLICANTS.

The Department of Health Services, Office of AIDS, authorizes the above payment(s) in the amount, for the period, and to the presentative payees as indicated.

➤
Authorized Signature _____ Date _____

Fiscal Year	PCA	Index	Object Code	Agency Object	Project Number	Work Phase

RYAN WHITE CARE ACT HEALTH INSURANCE PREMIUM PAYMENT REFERRAL

APPLICATION INSTRUCTIONS

The following instructions correspond to the numbered boxes on the face of the application. ALL boxes should be completed, except where indicated. Please print clearly and in ink.

1. **Name of Client**—Enter the name of the client.
2. **Client's Social Security Number**—Enter the social security number of the client. If this is the same as the policy or group number, enter "Same." **NOTE: This information is required because it is used to assist CARE/HIPP in identifying and tracking the premium payments.**
- 3-6. **Client's Address**—Enter the client's mailing address (number/street), city and county, state, and ZIP code of residence.
7. **Name of Policyholder and Social Security Number (If Different)**—If the client is covered under the policy of another individual, please specify the name of the policy holder and his/her social security number.
8. **Client's Telephone Number (Including Area Code)**—Please enter a daytime telephone number where the client can be reached.
9. **Insurance Company**—Enter the name of the insurance carrier.
10. **Policy and Group Number**—Enter the number used by the payee to identify the policy or the policyholder, whichever is applicable.
11. **Policy Status**—Enter the date on which the premium is/was due and date grace period ends.
- 11a. **State Use Only.**
12. **Monthly Premium Amount**—Enter the total amount of the monthly premium.
- 12a. **State Use Only.**
13. **Make Payment To**—Enter the name, address, telephone number (including area code) of the entity to which the premium payment is to be made. Also, please obtain the name of a payee representative.

IMPORTANT: Carefully review the information in the boxes prior to signing the completed application.

DECLARATION: The Declaration indicates that all eligibility requirements have been met.

AUTHORIZATION TO OBTAIN INFORMATION: Enter the name of the agency your benefits counselor represents on the blank line. This authorizes the benefits counselor to help you obtain information necessary for the submission of this application and the Department of Health Services to confirm information received.

SIGNATURES—Both the client and the policyholder are required to sign and date the application. If the client *is* the policyholder, sign on the second line only. If the client and policyholder are different, both lines must be signed.

AGENCY USE ONLY—Stop Here—Once you have come to this part of the application, return it to the benefits counselor with the required documents.